NH MEDICAL CONTROL Board

NH Fire Academy
Concord, NH

MINUTES OF MEETING

March 17, 2011

Members Present:	Patrick Lanzetta, MD; Kenneth Call, MD; Tom D'Aprix, MD; Chris Fore, MD; Frank Hubbell, DO; Mathurin Malby, MD; Jim Martin, MD; Douglas McVicar, MD; Jim Suozzi, MD; John Sutton, MD; Clay Odell, Bureau Chief
Members Absent::	Donavon Albertson, MD; Joseph Leahy, DO; Norman Yanofsky, MD;
Guests:	Aleda Nichols, Jeanne Erickson, Steve Erickson, Aaron McIntire, Stephen Robbins, Scott Hodgkins, Judy Weatherwax-Knight, Jim Chapin, Steve L'Heureux, Shawn Riley, Mark Hasting, Eric Schelberg, Fred Heinrich, Paul Leischner, Ted White, Scott Lancaster, Sean Ellbeg, Michael Pepin, Ronald, O'Keefe, Janet Houston, David Strang
Bureau Staff:	Vicki Blanchard, ALS Coordinator, Chip Cooper, QM & Research Coordinator, Kathy Doolan

I. CALL TO ORDER

D'Aprix called the meeting to order at 09:05.

EMS Community:
No report

II. ACCEPTANCE OF MINUTES

Item 1. January 2011 Minutes
Lanzetta moved to accept the January minutes. McVicar 2nd.Vote: Passed unanimously

III. DISCUSSION AND ACTION PROJECTS

Protocol Rollout Update
Blanchard reported that she was more than half through the 2011 NH Patient Care Protocol Rollouts. During the rollouts several errors were discovered. They were:

The Behavioral Emergencies was not included in the Table of Contents. Under the Poisoning Protocol and extra bullet was added to the Paramedic section for narcan which does not need to be there because it

is already in the Intermediate section. Additionally, the dose is incorrect as mg/kg. It is not a weight based drug.

Blanchard also forwarded the following comments or questions to the MCB regarding the protocols:

- For the pain protocol, can the providers use glucose instead of sucrose. Answer: No.
- For the sucrose dose, the protocol says pediatrics 0 – 4 months and the reference says 0 – 12 months. The board approved changing the age range to 0 – 12 months.
- Diabetic shock, or insulin shock. Is it okay for an Intermediate to start an IO for diabetic shock? Answer: No, hypoglycemia is not "shock" and we should take time to educate providers on this issue.
- Can solumedrol be used for adrenal insufficiency in the absence of hydrocortisone? Answer: No
- In the Advanced Spinal Assessment there was confusion to the high risk mechanisms of injury; in particular the > 60 mph. The group took it to mean if there was a MVC at < 60 mph the patient did not need an advanced spinal assessment. The board specified that this was not its intent and approved to rephrase the sentence: "All patients presenting with high risk or questionable injury mechanisms should have a spinal assessment", to read, All patients that have a mechanism of injury that could cause a spinal injuring i**ncluding** high risk or questionable injury mechanisms should have a spinal assessment."
- Under the Interfacility Transfer Protocol there where questions on the terminology, "pressure support." It was agreed to change "pressure" to read, "control".

2010 RSI Summary:
The board was presented earlier this week with the 2010 RSI Summary for review prior to the meeting. (see attached).

D'Aprix asked the board if going to a rescue airway should be considered a failed airway. Suozzie responded that it would indicate a failed intubation. Lanzetta stated if they are successful with the back up airway then it is successful airway management, but failed intubation. He added that it is important to keep track of who is failing at ETT to be sure the paramedics are properly selecting their patients. Suozzi concurred, adding it was important to watch for attempts and complications. Cooper stated that if the board came up with a standardized way to document RSI he would create a form for TEMSIS.

Blanchard is to call an RSI committee meeting and develop documentation standards and report back to the MCB.

Blanchard then reminded the board that earlier in the week an updated RSI Assistant PowerPoint and lesson plan was distributed for review. The new program culled much of the pharmacology from the original program, as it was deemed above and beyond the scope of the RSI assistant.

McVicar moved to accept the new RSI Assistant program. Call 2nd. Vote Unanimously passed.

Paramedic Interfacility Transfer and Critical Care Transfer PIFT/CCT:

D'Aprix stated that during the protocol rollouts and the PIFT train-the-trainer sessions questions had been raised which needed the board's consideration. First was the question of "What is an Interfacility transfer?

All agreed that a transfer from one acute care hospital to another should be considered "interfacility" Everyone also agreed that hospital to home or long term care facility should not.

Next there was discussion about transfer from an Urgent Care to an acute care hospital. All agreed that this was also not to be considered "interfacility" as it was really akin to a transfer from a doctor's office.

There was then discussion about a "Free Standing ED" to a hospital. The difference is that a free-standing ED can receive ambulances whereas an urgent care facility can not. This would primarily affect the satellite ED that St. Joseph Hospital operates in Millford. Significant discussion was had, but, ultimately no conclusion was reached and the board agreed to discuss it further at its next meeting.

David Strang, MD from Lakes Region General Healthcare was very concerned with the wording of the "Unstable or stable patient with high risk for deterioration" section of the protocols. He felt it severely constrained how they would move patients from his facility. He was in agreement that prerequisite part of the protocol calling for additional training was appropriate; he was concerned however with this category because he felt it would require him to wait for a CCT level crew. He gave an example of the current local protocol they are now working with where a crew would pick up a STEMI patient in the field and stop at LRGH to pick up a paramedic for transport to Concord for PCI.(AKA Hot Cot) The patient is not removed from the ambulance cot, but is given additional interventions and then moved to Concord. Under the new protocols, Strang felt that the paramedic would not be enough and he would have to call for a CCT team.

There was discussion regarding the responsibility of transferring a patient by sending a nurse to assist the paramedic versus waiting for a CCT crew. J Martin stated that raising the bar by giving the paramedics a little extra education was a band aid for a facility problem and that we are trying to fix a facility problem with EMS. He thought it was more of a violation to not send a nurse than to wait for a CCT crew.

Odell stated that he found Strang's interpretation of High Risk a surprise; an awake, alert, patient on some cardiac drips was intended to be a PIFT level call not CCT. It was never the intent of the PIFT/CCT committee for a STEMI patient to require a CCT crew. Odell also added that the Interfacility risk levels have not change since the 2007 protocols, so at this time with the scenario of the Hot Cot why are they not using CCT crew?

Sutton asked if the words, “potential risk for deterioration” or “high risk for deterioration” be removed or reworded. Cooper stated that the committee spent much time researching other states to see how stability was defined. Martin stated that there is a difference between a medical and a legal definition. Strang agreed that “high risk for deterioration” be taken out. Odell countered by stating that the language used in the protocols comes from the National NHTSA Interfacility Transfer Guidelines and is standardized national language. He again added that the same language was in the 2007 and 2009 protocols and was not a problem.

Odell then continued to add that questions will continue to come up. There is no way to write protocols for every single scenario possible. item out there. For issues that arise, the Bureau of EMS is developing a FAQ website similar to that found for the Board of Nursing. He envisions that questions similar to the appropriateness of an AMI patient being transported via PIFT vs. CCT would be posted there for all to see as the issues arise.

It was then suggested that the PIFT/CCT committee reconvene to look at the language for the PIFT and CCT levels of interfacility transfers. It was decided that Blanchard would get together the committee along with members of the Coordinatingand Medical Control Boards to look at the language.

Finally, the question came up as to time frame for the PIFT training and credential. Currently the Bureau of EMS has set the drop dead date as July 1, 2011. There was overwhelming support of the program however many felt there was not enough time between now and July to get the program up and running. Odell stated that he was willing to move the drop dead date up to September 1, 2011 to give agency a total of 6 months to complete training from the time the protocols were released.

D’Aprix commented that it was very disconcerting to him that all of this was being brought up now as the process had been discussed at every meeting for the last two years and because the EMS community was invited to participate in development of this protocol.

McVicar moved to move the implementation date to September 1, 2011 and have the PIFT/CCT committee meet with members of the MCB and Coordinating Board to address the description language of the PIFT and CCT level.” Call 2nd. Vote: Unanimously passed.

EMT Intermediate Transitions:

Blanchard informed the board that the National Education Standards for the Intermediates would not be rolled out until sometime in 2012. In light of that information, the Bureau has decided to go ahead and create transition modules in house, for nitroglycerin, nitronox, and glucagon for the Intermediates. It is expected that these programs will be available to the instructors by this summer and then in turn may be rolled out to the providers for the fall refresher season.

Extended Care Protocols

Blanchard reported that the Extended Care Protocol committee is meeting on the 3rd Thursdays of the even months. The committee met in February and spent most of the session brain storming. After the brain storming session it was determined the following items need to be addressed:

Credentialing or certification
Scope of Practice
Training
Medications
Instructors
Equipment/essentials.

D'Aprix questioned under what circumstances and by whom the protocols would be used. In NH a provider has to work under a licensed EMS agency and can not practice independently. So, how would a wilderness medicine protocol be utilized by a provider in the back country? Isn't that person using his skills in a "Good Samaritan"? How would protocols apply to such an individual? D'Aprix stated that we needed to first answer these issues before delving into protocols, training, etc. Hubbell agreed that this should be the committee's first goal.

Medical Director List serve

D'Aprix reported that the Bureau was able to procure a list serve for the medical directors. D'Aprix will send out some test invites and finish the set up. He asked for volunteers to send invites to. McVicar, Martin, and Suozzi volunteered.

STEMI/Stroke

D'Aprix explained that Blanchard would be sending out a survey to the EMS Hospital Coordinators regarding stroke care in NH. He found this an opportunity to gather more information on cardiac care. Specifically seeking to find out which hospitals perform primary PCI, which centers transfer their AMI patients, which hospitals perform therapeutic hypothermia on eligible patients and which would initiate this prior to transfer if deemed needed? .

McVicar expressed concern of getting 100% return on the survey. Blanchard stated she would contact those facilities that didn't respond to the initial request with follow-up letters and phone calls until she could get as close to 100% participation as possible.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

E911

S L'Heureux from E911 shared with the board their 3 year re-accreditation, which required them to meet 20 points. NH E911 was the 30th in the world to meet this accreditation. L'Heureux had a certification that he shared with the board.

ACEP: No report

Bureau and Division Update:

See attached.

Odell also reported that Chief Perry Plumber from Dover Fire was nominated by the Commission as the new Director for NH FST&EMS. The Coordinating Board will be meeting with the Chief this afternoon.

Odell also reported that the Ad Hoc Committee for the refresher process has completed their report. Odell and Chief Andrus, chairman of the committee, met with the Commissioner and ask to bring it forward to the Coordinating Board. Odell want to acknowledge the work they did and the fact that they were able to get done before their deadline.

Odell stated that there was no news of the budget at this time. They were asked to reduce it by 5% which has been done. He added that the legislature has been reviewing budgets by divisions, and our division had not yet been reviewed, but he felt EMS would not be affected.

Lastly, Odell stated that the last refresher practical will be held at the Fire Academy on March 29, 2011. With the topic of exams raised, D'Aprix reported that the protocol committee was developing a 2011 Protocol Exam. He would then send it to his education people at the hospital to review.

Legislative Updates:
Odell stated none from the Bureau.
S Robbins from the Ambulance Association, reported that HB31, which will require Anthem billing send the money to the ambulance services and not the patient, has made it through the legislative body and is going on to the Senate.

Coordinating Board Update:
Suozzi reported that the Best Practice Committee is working on the lights and siren best practice. Specifically they are looking at insurance company input, and are they requiring ambulances to run lights and siren if a patient is in the compartment. Additionally a Benchmark Committee has been formed to look at chest pain and stroke QA/QI.

Critical Care Paramedic Task Force:
See above.

Stroke/STEMI Development:
Blanchard will be participating in the Stroke Steering Committee with DHHS.
See above regarding survey.

TEMSIS Update:
Cooper reported that the EMS Medical Director online training has been updated. He stated it is free and would receive 12 CEUs. It is funded by Rural Health.

An EMS Data Advisory Committee is being formed to define NH's data set for reporting. Rural Health funding is helping to form a NE EMS Data Council, it would include CT, MA, ME, NH, RI, & VT. They would work on regional benchmarks. He stated that they all share the same software so should be relatively easy. He did stress it was very much in its infancy stage.

Trauma System:
Sutton reported that they are working with Littleton on their reaccreditation and would be spending much of the year reaccrediting other hospitals throughout the state. Additionally, he stated the IRB for the Vacuum Board Study has been

approved by the Institutional Review Board at Dartmouth and data is being collected.

Trauma Conference: Sutton stated that we have been having a trauma conference for more than ten years, and they have found the attendance not as robust as of late. He would like to suggest a system-wide conference with the Trauma Medical Review Committee, the Coordinating Board, and the Medical Control Board and appeal to a greater audience. D'Aprix liked the idea. McVicar also liked the idea. Sutton suggested a subcommittee be formed with member from each board. Odell stated we would also have to let the Coordinating Board know.

Other Business:

One of the ideas that was discussed at the last MCB meeting was of a review of outcomes for cardiac arrest in NH D'Aprix stated that currently there is not a way to look at cardiac arrest outcomes to see if we are meeting any national standards. He would like to work with the hospitals to find out the outcomes, did they go home? Rehab? Die? But, it is a herculean task and could take a full time person to track down the information. Martin asked if we know if the Hospital Association does this already or someone else. McVicar pointed out that linking the data is not always easy and wondered if we need to update TEMSIS first?

Cooper stated that there are quite a few data points in TEMSIS that we could use. He stated in a similar fashion as we will create a reporting standard for RSI; we could also do so for cardiac arrest. He added that we do have some linkage with public health; the problem is their data is a year or two behind. Additionally 12 – 14 hospitals do have live discharge data of whether the patient went home or died, but not if they were moved out of the E.D. Jaeger pointed out that this was the second time today we are discussing what is being put into TEMSIS and the need for reporting standards. He added that he would like to know more about STEMI patients. D'Aprix agreed that maybe start with standardizing data RSI, Cardiac Arrest, and Acute Coronary Syndrome (ACS), and then later we could link in hospital data. Odell suggested starting with something fairly easy like documenting aspirin in ACS. Cooper said it would be a bit complex with E911 instructing patients to take hospitals before EMS arrives. Odell reminded the group that there is a benchmark committee on the Coordinating Board and we should partner with them. It was then suggested to start with RSI as there are only 200 or so and try to link with them and their outcomes. D'Aprix proposed that Cooper and himself get together and come back in May with more information.

ADJOURNMENT

Meeting adjourned at 11:55

VI. NEXT MEETING

May 19, 2011 NH Fire Academy, Concord, NH.

Respectfully Submitted,

Clay Odell, EMTP, RN, Bureau Chief

Prepared by Vicki Blanchard, ALS Coordinator